



Center for Medicaid, CHIP, and Survey & Certification

September 29, 2010

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NCCI Subworkgroup
The National Medicaid EDI Healthcare Workgroup
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Dear Ms. Weinberger:

Thank you for the important letter from the National Medicaid EDI Healthcare (NMEH) Workgroup dated September 14, 2010, reviewing the State Medicaid Director Letter #10-017, dated September 1, 2010, on implementation of the National Correct Coding Initiative (NCCI) in Medicaid. This State Medicaid Director Letter provides guidance to States regarding implementation of section 6507 of the Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Recovery Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act. The NMEH correspondence requests clarifications of this State Medicaid Direct Letter and responses to specific questions about the Letter. CMS' responses follow the questions and requests in each section of NMEH's letter.

1. **Types of Providers Subject to NCCI edits for Medicaid** (Page 3, Paragraph 2 and Page 14, Paragraph 2)

- Please provide the definition of 'practitioner' and 'facility therapy services'.

"Facility Therapy Services" as used operationally in the Medicare program to adjudicate claims (submitted to the Fiscal Intermediaries) using NCCI edits in OCE includes all services submitted as HCPCS / CPT codes from outpatient SNF, CORF services, outpatient home health (Part B only), and clinic outpatient physical therapy and speech pathology services (outpatient rehab facilities). Under Medicare, many types of claims from these sites of service are covered under payment methodologies that do not rely on HCPCS / CPT codes, such as consolidated billing.

We were referred to Section 1905(a)(5)(A) of the Social Security Act by CMS when we requested the definition of 'practitioner'. We have reviewed the reference to 'physician's services' and found the following information:

1905(a)(5)(A) physicians' services furnished by a physician (as defined in section [1861\(r\)\(1\)](#)), whether furnished in the office, the patient's home, a hospital, or a nursing facility, or elsewhere, and (B) medical

and surgical services furnished by a **dentist** (described in section [1861\(r\)\(2\)](#)) to the extent such services may be performed under State law either by a doctor of medicine or by a doctor of dental surgery or dental medicine and would be described in clause (A) if furnished by a physician (as defined in section [1861\(r\)\(1\)](#))

*1861(r) The term “physician”, when used in connection with the performance of any function or action, means (1) a **doctor of medicine** or **osteopathy** legally authorized to practice medicine and surgery by the State in which he performs such function or action (including a physician within the meaning of section [1101\(a\)\(7\)](#)), (2) a **doctor of dental surgery** or of **dental medicine** who is legally authorized to practice dentistry by the State in which he performs such function and who is acting within the scope of his license when he performs such functions, (3) a **doctor of podiatric medicine** for the purposes of subsections (k), (m), (p)(1), and (s) of this section and sections [1814\(a\)](#), [1832\(a\)\(2\)\(F\)\(ii\)](#), and [1835](#) but only with respect to functions which he is legally authorized to perform as such by the State in which he performs them, (4) a **doctor of optometry**, but only for purposes of subsection (p)(1) with respect to the provision of items or services described in subsection (s) which he is legally authorized to perform as a doctor of optometry by the State in which he performs them, or (5) a **chiropractor** who is licensed as such by the State (or in a State which does not license chiropractors as such, is legally authorized to perform the services of a chiropractor in the jurisdiction in which he performs such services), and who meets uniform minimum standards promulgated by the Secretary, but only for the purpose of sections [1861\(s\)\(1\)](#) and [1861\(s\)\(2\)\(A\)](#) and only with respect to treatment by means of manual manipulation of the spine (to correct a subluxation) which he is legally authorized to perform by the State or jurisdiction in which such treatment is provided. For the purposes of section [1862\(a\)\(4\)](#) and subject to the limitations and conditions provided in the previous sentence, such term includes a doctor of one of the arts, specified in such previous sentence, legally authorized to practice such art in the country in which the inpatient hospital services (referred to in such section [1862\(a\)\(4\)](#)) are furnished...*

Medicaid enrolls many different types of providers and it is uncertain which ones this policy should be applied to beyond those listed in sections 1905 and 1861 of the SSA (Doctor of Medicine, Doctor of Osteopathy, Dentist, Podiatrist, Optometrist, and Chiropractor).

For example:

- Physician Assistant
- Nurse Practitioner
- Registered Nurse
- Licensed Practical Nurse
- Nurse Anesthetist
- Certified Registered Nurse Anesthetist
- Physical Therapist
- Physical Therapy Assistant
- Occupation Therapist
- Occupational Therapy Assistant
- Speech Pathologist
- Speech Pathology Assistant
- Licensed Clinical Social Worker
- Community Health Aide/Practitioner
- Optician
- Psychologist

- Behavioral Therapist
- Dietician, Nutritionist
- Nurse Midwife
- Certified Nurse Midwife
- Prosthetic and Orthotic Supplier
- Other Midlevel Providers

Perhaps it makes more sense to simply apply the edits to any providers who are permitted to bill/render the CPT/HCPCS codes that are subject to the NCCI edits. The edits would essentially be applicable to any type of provider that is authorized to bill them. Given this strategy, it would still be possible to exempt certain types of providers if necessary.

- Is it an acceptable strategy to apply the NCCI edits to all providers allowed to bill the codes connected to these edits?

The CMS agrees that this is an acceptable strategy. Additionally, in considering the types of providers listed, States must consider the Federal regulations on scope of practice; e.g., 42 CFR 440.60 (practitioners), 42 CFR 440.100(b) (dentists), 42 CFR 440.165 (nurse midwife), and 42 CFR 440.166 (nurse practitioner services).

- If States are afforded the flexibility to apply the edits to providers beyond those listed in the SSA (Doctor of Medicine, Doctor of Osteopathy, Dentist, Podiatrist, Optometrist, and Chiropractor), are States required to request approval from CMS to do so?

The CMS is not requiring that States request prior approval to apply edits to providers beyond those listed in the Social Security Act. However, CMS is requesting that each State report to its CMS Regional Office through an Advance Planning Document (APD) the types of other provider claims that will be subject to the Medicaid NCCI methodologies in the State.

- Are FQHC and tribal clinic providers exempt from NCCI?

FQHC and tribal clinic providers are exempt from NCCI only if they do not submit claims to the State's Medicaid program based on HCPCS / CPT codes and / or only if FQHC and tribal clinic providers do not bill the State's Medicaid program directly. If providers within these settings bill the State's Medicaid program directly using HCPCS/CPT codes, NCCI edits must be applied to those claims for payment.

2. **Outpatient Hospitals Subject to the Procedure-to-Procedure Edits** [Page 3, Paragraph 2, Number 2 and Page 14, Paragraph 2, Number 7 (assumption is that the numbering on page 14 is a typo and should be 1-5 versus 6-10)]

The methodologies for Medicare Part B state that the procedure-to-procedure edits for outpatient hospital services apply to hospitals reimbursed through the Outpatient Prospective Payment System (OPPS) and that they do not apply to hospitals that are not reimbursed through the OPPS.

Medicare does apply NCCI edits to hospitals reimbursed under OPPTS. However, this does not necessarily mean that the edits would not also apply to other hospitals that bill and are reimbursed using HCPCS / CPT codes.

We wish to point out that the basis of the NCCI edits applied by Medicare to outpatient hospital services billed and paid using HCPCS / CPT codes under OPPTS is Medicare coding policy and is not specific to OPPTS.

The Medicaid methodologies on page 14 also state that the procedure-to-procedure edits for outpatient hospital services apply to hospitals reimbursed through the OPPTS.

The CMS believes that the NMEH NCCI workgroup is making specific reference to page 14 of the State Medicaid Direct Letter #10-017. As such, we advise that the text on page 14 states that the NCCI procedure-to-procedure edits for outpatient hospital services are *derived* from Medicare NCCI edits for outpatient hospital services incorporated into the Medicare OCE for OPPTS hospitals.

Therefore, it follows that for the Medicaid methodologies the procedure-to-procedure edits for outpatient hospital services do not apply to hospitals that are not reimbursed through the OPPTS.

While some Medicaid programs pay outpatient hospitals via the OPPTS, many do not use this payment system.

- Please confirm that hospitals that are **not** reimbursed via the OPPTS are **not** subject to these procedure-to-procedure edits.

Claims for outpatient hospital services that are submitted to a State's Medicaid program using HCPCS / CPT codes are subject to the Medicaid NCCI methodologies regardless of whether the State uses a prospective payment methodology. Enclosure B to the State Medicaid Director Letter #10-017 specifically makes reference to the nature and structure of Medicaid NCCI methodologies and includes information regarding the five NCCI methodologies that will be applied in Medicaid. It should be noted that the Medicaid NCCI methodology for outpatient hospital services are NCCI procedure-to-procedure edits for outpatient hospital services and all facility therapy services that are *derived* from the Medicare NCCI edits for outpatient hospital service.

3. Outpatient Hospitals Subject to the Procedure-to-Procedure Edits

Many Medicaid programs use revenue codes and do not use CPT/HCPCS codes on outpatient claims to pay some services. Also, some claims may be paid based on per diem or rate per visit and may or may not use CPT/HCPCS on these claims. In this case CPT/HCPCS codes may not be edited against.

- Does the NCCI implementation require Medicaid to change their reimbursement methodology to discontinue per diem and rate per visit?

The CMS is not requiring that States revise their respective payment policies. However, CMS is requesting that a State notify its CMS Regional Office through the APD process of such payment policies that conflict with the Medicaid NCCI methodologies.

- Is it acceptable to continue paying claims on a per visit or per diem basis and not subject them to the Medicaid NCCI (MCDNCCI) edits?

This is an acceptable approach only for those States that pay claims in this manner. All other States that pay hospital outpatient services based on the HCPCS / CPT codes must use the Medicaid NCCI methodologies for outpatient hospital services.

- Does CMS have a recommended approach on whether the per diem or per visit payments should be impacted and if so, how these payments should be impacted?

As noted above, these claims are not impacted by the Medicaid NCCI methodologies.

- If the NCCI edits are to be applied to all claims that contain CPT / HCPCS, even if the payment is not based on the CPT / HCPCS, is the Medicaid Program required to deny the entire claim?

The CMS believes that, even if the payment is not based on CPT / HCPCS codes, it may be valuable for a State to apply the Medicaid NCCI methodologies to each claim; however, CMS is not requiring this.

4. **Effective Date Criteria** (Page 3, Paragraph 3)

Please clarify what is meant by ‘claims filed on or after October 1, 2010’.

- If a Medicaid Program is not ready on 10/01/2010 to apply the MCDNCCI edits does the program need to apply the edits retroactively to 10/01/2010?

The CMS is not requiring that a State retroactively apply Medicaid NCCI edits if the State has an approved APD signaling to CMS that the State is not ready to implement the Medicaid NCCI methodologies on October 1, 2010.

- Is it acceptable to implement the edits on or before 04/01/2011 and apply the edits retroactively to claims received on and after 10/01/2010?

The CMS notes that this is an acceptable approach if a State is in a position to do so.

- Does this apply to claims received / adjudicated or claims submitted on or after 10/01/2010?

The NCCI methodologies apply to claims with a date of service on or after October 1, 2010. Please see the document on Medicaid NCCI “File Names and Formats, Algorithms for Processing Claims, and Characteristics of Edits” on the CMS Website on the new Medicaid NCCI Coding webpage.

- Does this apply to adjustments received / adjudicated on or after 10/01/2010 to claims that were received prior to 10/01/2010?

It applies to claims with a date of service on or after October 1, 2010. If the adjustment applies to a claim received prior to 10/1/2010, NCCI methodology edits would not apply because the date of service would antedate 10/1/2010.

- Does this apply to adjustments received / adjudicated on or after 10/01/2010 to claims that were received on or after 10/01/2010?

It applies to claims with a date of service on or after October 1, 2010. If the adjustment applies to services with date of service on or after 10/1/2010, the NCCI methodology edits would be applied.

- Is the requirement to edit all claims regardless of Date of Service against the edits that were in place on the date of service?

It applies to claims with a date of service on or after October 1, 2010. If a claim contains HCPCS/CPT codes with a date of service on or after October 1, 2010, NCCI methodology edits must be applied to those services. The only applicable edits are those edits where the DOS is on or after the effective date of the edit and on or before the deletion date if there is a deletion date.

The NCCI edits are updated quarterly and have effective and end dates associated with each. It is our understanding that Medicare applies the edits based on the edit that was effective for the date the claim was received/adjudicated. It is assumed that Medicaid must apply the edits in this same manner without regard to the date of service.

Medicare applies the edits based on the date of service of the claim.

- The NMEH recommends that Medicaid apply the edits based on the date of receipt / adjudication regardless of the date of service.

The NCCI edits and MUEs in the Medicaid NCCI methodologies apply to claims with a date of service on or after October 1, 2010. We wish to point out that this approach is consistent with the application of the NCCI in Medicare as well.

5. Applicability to Medicare Crossover Claims

NMEH requests clarification on whether Medicaid should apply the edits to Medicare Crossover claims, and if so, how we will determine when Medicare has made an exception to the edits.

- When Medicare has re-bundled services does Medicare send the submitted codes or the re-bundled codes on the crossover claim?
- Also, since the MUE units of service edits are applied to each line separately, how will Medicaid know what the Medicare policies are that allow separate detail lines for the same procedure codes?

The State of Tennessee conducted a brief analysis on several files of Medicare Crossover Claims. Two files of Medicare crossover claims were processed in the Medicaid system and were subjected to the procedure-to-procedure edits in NCCI. The Medically Unlikely Edits (MUE) were not included in this analysis. The following were the findings:

- Of a file of 7,279 Medicare crossover 837I claims, 791 were rejected for procedure-to-procedure NCCI edits in the Medicaid system.

- Of a file of 46,661 Medicare crossover 837P claims, 243 were rejected for procedure-to-procedure NCCI edits in the Medicaid system.

This is a concern as we are not able to determine when Medicare has made an exception and whether or not we should also override the NCCI edits. The NMEH recommends that Medicare Crossover Claims not be subject to the MCDNCCI edits in the Medicaid system as we are mandated to pay the coinsurance and deductible on these claims.

The CMS wishes to work with the NMEH to further understand the implementation issues regard the Medicaid NCCI methodologies and Medicare crossover claims. However, CMS' initial position on this issue is that, if a Medicare claim is denied and later is submitted to Medicaid for payment, States should consider processing such claims considering Medicaid NCCI methodologies. However, since we believe that a Medicare cross-over claim is one in which Medicaid is simply paying the deductible or cost-sharing, CMS believes that the Medicaid NCCI methodologies should not be applied.

6. Applicability to Managed Care Encounters

Some States have recipients enrolled in Managed Care and therefore receive encounter claims from the Managed Care Organizations (MCOs).

- Are the State contracted MCOs exempt from complying with MCDNCCI since they operate at risk and have their own internal reimbursement methodologies?
- Since this is a new requirement that is not currently included in the contracts with the MCOs, is the State eligible for federal funding to implement MCDNCCI within the State contracted MCOs if the MCOs are required to use MCDNCCI?
- Does CMS have a recommended approach for MCDNCCI edits related to MCOs?
- Is it required for the State to edit the encounter claims against the MCDNCCI edits? If this is the case, these claims have already been adjudicated by the MCO. Some of the current NCCI edits require a review prior to payment. Since these encounters are already adjudicated, this will not be possible.
- If it is required for the State to edit the encounter claims against the MCDNCCI edits, does CMS have a recommendation on how encounters are to be re-processed? We are not aware of any indicator that can be used to identify that an NCCI edit exception review has been completed by the payer.

At this time, the Medicaid NCCI methodologies do not apply to encounter claims. However, CMS has provided flexibility to States to apply the Medicaid NCCI methodologies to other sites of service, including managed care plans. CMS has provided information regarding this as part of the State Medicaid Director Letter #10-017. States can receive further guidance in an Advance Planning Document (APD) template being released to the CMS Regional Offices. CMS recommends that a State contact its CMS Regional Office early and often to discuss the APD process, implementation of the Medicaid NCCI methodologies, and the flexibilities afforded States that are outlined in the State Medicaid Director Letter #10-017.

7. Applicability to Professional Services Not Reimbursed Through RBRVS

Some State Medicaid Programs do not base their reimbursement of professional services upon RBRVS. Since NCCI edits for professional services are based on the RBRVS these edits may not be applicable for some Medicaid programs.

- The States request the flexibility to exempt services that are not reimbursed based on the RBRVS from the MCDNCCI edits.

The Medicaid NCCI methodologies apply to claims based on HCPCS / CPT codes. Medicare NCCI edits for professional services are NOT based on RBRVS. However, some edits use the RBRVS to determine which code may be the column one code versus the column two code. Whether a State uses a reimbursement system based on RBRVS does NOT affect the applicability of NCCI edits for professional services.

8. When to Contact CCS (Page 4, Paragraph 3 and Page 9, Paragraph 1)

Page 4 states that Medicaid programs should contact CCS when they identify ‘incompatible edits’.

Since each of the 50 Medicaid programs its own unique State regulations and policies, it may not know whether an edit that is incompatible for its State is necessarily incompatible for all Medicaid programs. Each State will be submitting the edits they find to be incompatible with its State laws, polices, regulations, reimbursement methodologies, etc. via the APD process by March 1, 2011. We recommend that CMS identify those edits that are common across all States by analyzing the submissions from multiple states and for CMS to notify CCS of needed revisions to the MCDNCCI.

The CMS’ approach is to complete a review and analysis of all APDs and to perform an assessment of national issues that impact the effective implementation of the Medicaid NCCI methodologies.

Page 9 indicates to direct questions related to ‘reconsideration of MCDNCCI edits’ to CCS.

Please clarify what is meant by ‘reconsideration’.

Reconsideration is the process of determining whether an edit in its current active form requires modification or deletion from MCDNCCI because it is incompatible with the Medicaid program. The reconsideration request identifying specific edits and the rationale for the reconsideration is submitted to CCS LLC which analyzes the request. This analysis is submitted to the CMS Medicaid NCCI Workgroup which will decide whether the specified edits should be modified or deleted. After CMS decides upon a course of action, a letter is sent to the individual or entity requesting the reconsideration. A reconsideration may be requested by a State Medicaid program, a State Medicaid medical director, CMS-RO, CMS-CO, national or local healthcare organizations, providers, consultants, and other interested parties. It is important to distinguish the types of issues that should be sent to CCS LLC for reconsideration. Since the decisions related to reconsiderations will impact the national MCDNCCI edit files, the edit issues must be ones that impact the vast majority, if not all, Medicaid programs. If there are edit incompatibilities for an individual State based on that State’s laws, regulations, administrative policies, or payment policies, these incompatibilities should be addressed through the APD process, NOT a reconsideration request sent to CCS LLC.

- Does this pertain to edits that the State believes are medically inaccurate?

If a State believes that an edit is medically inaccurate, a modification of the edit would impact all States. It would be appropriate to send this type of reconsideration request to CCS LLC. Similarly,

if a State believes that an edit is based on incorrect coding principles, this issue would impact all States, and it would be appropriate to send a reconsideration request to CCS LLC. However, if an edit is incompatible with an individual State program because of that State's laws, regulations, administrative policies or payment policies, a reconsideration request should NOT be sent to CCS LLC, but an APD should be submitted to the RO.

- Does this pertain to any edit that the State finds to be incompatible with their program?

No. A State should submit by March 1, 2011, an APD to its CMS Regional Office to request CMS approval to deactivate after March 31, 2011, only those edits which conflict with individual State law, regulation, administrative rule, or payment policy.

At a point in time, all APDs will be reviewed and an analysis will be completed to determine if there are certain edits at a national level that are incompatible with the Medicaid NCCI methodologies.

9. Requesting Deactivation of Edits (Page 4, Paragraph 5)

The first sentence indicates that CMS will use the APD process to approve State deactivation of edits after reviewing State documentation confirming that the edit is in direct conflict with State laws, regulations, administrative rules, payment policies, and/or the State's level of operational readiness. The last sentence indicates that States will not be afforded the flexibility to deactivate edits after March 31, 2011 because of lack of operational readiness.

Please clarify why 'and / or the State's level of operational readiness' is included in the first sentence.

- Does this mean that any State that is not editing fully by 10/01/2010 must submit an APD requesting 'deactivation' of all edits until such time prior to 04/01/2011 that they are ready?

A State may unilaterally deactivate edits without prior CMS approval before April 1, 2011, for the reasons specified above. However, a State can deactivate edits after March 31, 2011, only with prior CMS approval due to a conflict with State law, regulation, administrative rule, or payment policy.

It is likely that some of the incompatibilities will not be identified until after 04/01/2011 when the edits are turned on.

- When this occurs, will CMS allow States to request deactivation of edits after 04/01/2011?

States have the flexibility to submit APDs and / or APD updates as necessary.

- After 04/01/2011, will CMS allow States to deactivate an edit in urgent situations prior to obtaining approval from CMS as long as the state communicates the decision and reasoning to CMS in a reasonable timeframe and works with CMS to obtain retro-active approval?

This flexibility has not been extended to States. A State should submit to its CMS Regional Office an APD requesting CMS approval to deactivate the edits with the rationale and supporting documentation. CMS will make decisions on such requests quickly.

10. State Flexibility to Incorporate NCCI Methodologies/Edits beyond CMS' Requirements
(Page 5, Paragraph 2)

The first sentence indicates that States can apply additional NCCI methodologies to service types not currently implemented... The last sentence indicates that States should contact CMS to discuss/receive approval to incorporate additional NCCI methodologies/edits...

Medicaid programs have many edits in place today that may reflect those in NCCI. States typically have had the ability to utilize requirements that are more stringent than Federal requirements. Therefore, NMEH requests that it be clarified that approval is not mandatory to impose additional NCCI methodologies/edits.

- Are States required to request approval to apply edits when we are not required to do so today?

Prior CMS approval is not required. However, CMS is requesting that States report these additions to its CMS Regional Office through the APD process. These edits should be separate from the NCCI methodology edit files and denials of claims due to them should not be categorized as NCCI edit methodology denials.

11. Timing of Medicare and Medicaid NCCI Files (Page 7, Paragraph 3)

- Please clarify which Medicaid files will lag the Medicare files.

For October 1, 2010, the only file synchronous with Medicare is the outpatient hospital NCCI file. The other four files lag by one quarter with some modifications based on edit deletions and modifications in Medicare files for October 1, 2010.

The Medicaid and Medicare files will all be synchronous effective January 1, 2011.

12. Format of Files

- Is the MCDNCCI code set in the same format as the Medicare code set?

The file formats are the same, with two exceptions: (1) the Medicaid NCCI methodology files do not include the Medicare rebundling indicator and (2) in the Medicaid NCCI methodology files there is one column one / column two correct coding edit (CCE) file that includes the edits from both the Medicare CCE file and mutually exclusive (ME) edit files.

13. Confidentiality Agreements with COTS Vendors (Page 8, Paragraph 4 and 5)

- If States are required to provide the confidential MCDNCCI files to the vendors there will be an additional delay in implementing the on-going changes. This also puts the burden on the States to maintain additional confidentiality agreements and to provide the files. Is it possible for CMS to provide the confidential files to the vendors?

CMS does not believe this is appropriate in regards to the statute. Consequently, States must be responsible for forwarding the files to their vendors and for maintaining the confidentiality of the files.

- Can CMS provide a template for the confidentiality agreement?

CMS believes that, based on an earlier conference call with the State Medicaid NCCI workgroup, States had confidentiality agreements in place with their vendors that would be modified to include these files.

- It is very likely that a COTS vendor has edits that are comparable to those in the Medicare and Medicaid NCCI edits, since many of the edits are straight forward based on the code descriptions and coding guidelines. How can vendors document their own edits to protect themselves from penalties?

Section 6507 of the Affordable Care Act requires that the National Correct Coding Initiative be implemented in State systems for processing Medicaid claims. The vehicle for doing this is the set of Medicaid NCCI methodologies provided by CMS for States. A State Medicaid agency can expand and extend these methodologies and add other methodologies and edits at its discretion, but it cannot reduce or contract these methodologies. After March 31, 2011, it can only deactivate edits within these methodologies with prior approval from CMS. A State Medicaid program cannot substitute other software and / or vendor files for the Medicaid NCCI methodologies.

14. **Federal Financial Participation** (Page 7, Paragraph 5 and 6)

The letter indicates that 90% FFP is available for the design, development, and installation and 75% is available for maintenance and operations.

- Each quarter when updates are released a detailed analysis will need to be conducted to ensure that the changes are not in conflict with State law, policies, etc. This work effort could be significant as shown by a previous quarterly update that went from 325,000 to over 600,000 edits. Given that the analysis must be completed and the changes implemented quarterly, this is not typical maintenance and operation. Each set of quarterly files will need to be analyzed before they are implemented. The NMEH requests that CMS consider 90% FFP for these activities.

Ninety percent FFP will be available for State expenditures for that purpose.

The letter indicates that if States can verify to CMS that the State was involved in making changes to its MMIS to incorporate NCCI methodologies prior to the release date of this letter, FFP may be available.

That is correct. However, FFP will be available only for State expenditures on or after March 23, 2010.

- Please clarify that, if a State started its NCCI activities after the release date of this letter, FFP will be available retroactive to the date the work was started.

FFP will be available retroactively for a State's expenditures to implement the NCCI in its Medicaid program no earlier than March 23, 2010, with submission of an APD to its CMS Regional Office and documentation of the expenditures and the work performed.

15. Quarterly Updates to MCDNCCI Files

- Since the quarterly updates may include significant changes, will CMS consider having CCS provide a separate file that outlines the changes?

The CMS is currently discussing this with CCS LLC. CMS will advise States about this once a decision has been reached.

16. Reporting

Many States already use tools and edits that may be reflective of NCCI edits. For example, some states are currently using ClaimCheck. The implementation of NCCI may not increase these savings. Therefore, States will exclude savings that were realized elsewhere from the NCCI savings reports. The States request clear guidelines on accurately reporting savings for NCCI.

- When will the format of the report, the distribution of the report, the data specifications, and the media for the reporting be made available?

The information reported should be broken down by:

- calendar quarter;

- the five Medicaid NCCI methodologies; and

- the type of provider / practitioner.

The CMS will allow State flexibility in other aspects of reporting because capabilities in reporting vary among States.

- Please include in the data specifications for the reporting whether dollars paid as the result of an appeal should be included.

Dollar amounts paid as the result of an appeal should be reported. However, the amounts should be separately identified.

- Who will audit the reports?

The CMS Regional Offices are responsible for ensuring that State Medicaid programs are in compliance with Federal Medicaid policies.

The CMS CO is responsible for NCCI coding policies in Medicaid and will work with the CMS Regional Offices in reviewing the Medicaid NCCI reports submitted by State Medicaid programs.

- What penalties will apply for late or inaccurate reporting?

States are responsible for ensuring that up-to-date information is accurate.

- Will CMS be supporting new Adjustment Reason Codes to inform downstream adjudicators of any NCCI decisions? For example: Denied due to NCCI edit, Paid after NCCI review, etc.

The CMS is not supporting national reason codes at this time. However, we have provided examples of responses for denials that States may wish to consider in the document on Medicaid NCCI “File Names and Formats, Algorithms For Processing Claims, and Characteristics of Edits” on the CMS Website on the new Medicaid NCCI Coding webpage.

- Will CMS be supporting new Remark Codes to allow specific information to be passed to the provider via the 835?

The CMS is not supporting national remark codes at this time. However, we have provided examples of responses for denials that States may wish to consider in the document on Medicaid NCCI “File Names and Formats, Algorithms For Processing Claims, and Characteristics of Edits” on the CMS Website on the new Medicaid NCCI Coding webpage.

17. Appeals

- If the State does not have an appeal process for providers, are they required to implement one for NCCI?

States are required to implement an appeals process specific to the implementation of the NCCI methodologies in their Medicaid programs.

- If so, please provide clarification of the process.

A provider may appeal a denial due to an NCCI methodology edit. We included information regarding the appeals process in the document on Medicaid NCCI “Claims Appeals Process” on the Medicaid Integrity Institute WorkSpace website.

If you have any questions regarding these responses and on issues surrounding the requirements of section 6507 of the State Medicaid Director Letter #10-017, please feel free to contact Paul Youket of my staff at Paul.Youket@cms.hhs.gov. We look forward to working with the NMEH NCCI subworkgroup, as we implement this important legislation.

The CMS respectfully requests a meeting with the NMEH NCCI subworkgroup to discuss these responses. CMS has scheduled the discussion for this Thursday, September 30, 2010, from 11:30 a.m. to 1:00 p.m. Eastern time.

Sincerely,

/s/

Richard H. Friedman, Director
Division of State Systems
Data and Systems Group